Quick Reference for Denti-Cal Dentists

(This is a summary of key information and requirements of the Denti-Cal program. It is not meant to replace the detailed information in the Denti-Cal Provider Handbook.)

I. PROCESSING A DENTI-CAL PATIENT THROUGH THE DENTAL PRACTICE

Above all: Dentist must be enrolled as a Denti-Cal provider

- The first criterion for treating Denti-Cal patients is to assure that every dentist in the office providing care to Denti-Cal patients is enrolled as a Denti-Cal provider.
- Enrollment applies to both "billing providers" (i.e., the practice owner) and "rendering providers" (i.e., any associate treating Denti-Cal patients).
- **DO NOT HAVE A NON-ENROLLED DENTIST TREAT DENTI-CAL PATIENTS…EVER!**
- See **page 3-1** of the "Medi-Cal Dental Program Provider Handbook", and the "Enrollment Tool Kit" under the Provider tab at http://www.denti-cal.ca.gov

Verifying patient eligibility:

- Make a copy of the patient's Medi-Cal Benefits Identification Card (BIC).
- Verify and copy patient's photo identification. Copy the parent's identification if the patient is a minor.
- Patient eligibility should be verified one time each month that services are provided. Eligibility may be verified electronically over the Internet (https:www.medi-cal.ca.gov/Eligibility/Login.asp), or through a Point of Service device. See **page 4-4** of the Provider Handbook, or call the POS/Internet Help Desk at **(800) 427-1295**.
- See **page 4-3** of the Provider Handbook on verifying patient eligibility.

Important information for providers:
Dental offices may acquire a variety of information about the patient's history, the status of a claim, and their provider enrollment status, by calling **800-423-0507** and following the prompts to access specific information.

Required Patient Information:
Keep in mind that the Department of Health Care Services' philosophy is "show us what you saw when you made the diagnosis."

- Take necessary radiographs when making a diagnosis, so Denti-Cal can see how your radiograph(s) help to substantiate your diagnosis.
- Radiographs are required for many procedures to show medical necessity of treatment. (See **page 2-17** of the Provider Handbook.)
- Intraoral photographs of teeth are needed on all occlusal, buccal, lingual tooth surfaces to document caries not seen on radiographs, or for any other clinical situations you may need to demonstrate.
- Radiographs are required to justify medical necessity when prior-authorizing scaling and root

planing, crowns, dentures and root canal therapy.
- All perio procedures require submission of radiographs and perio charting.
- Copy all radiographs, photos, and notes you send to Denti-Cal for your own records.

What is covered:

- Patients up to age 21 enrolled as Medi-Cal beneficiaries are eligible for Denti-Cal.
- All covered Denti-Cal benefits, with diagnostic policies and documentation requirements, are in Section 5, *Manual of Criteria and Schedule of Maximum Allowances,* of the Provider Handbook, beginning on **page 5-5**.
- Common procedures – examinations, prophylaxis, amalgam and composite fillings, stainless steel crowns, pulpotomies, space maintainers, dental sealants, and all emergency procedures – are paid without prior authorization.
- Note policies on covered orthodontic procedures on page **5-103**, and ortho procedures requiring prior authorization on page **2-19** of the Provider Handbook.
- Prior authorization is needed for root canal therapy, cast crowns, and is recommended for extraction of third molars. (See **page 6-6** of the Provider Handbook for requesting prior authorization.)
  - ✓ For further clarification on Denti-Cal's policy on third molar extraction, see the January 2011 Denti-Cal Bulletin, and the CDA *UPDATE* of July 2011.
- Adults over 21 are eligible for:
  - ✓ certain services identified as "Federally Required Adult Dental Services (FRADS)" (see **page 4-8** of the Provider Handbook);
  - ✓ dental services necessary as a condition for other covered medical treatment such as organ transplantation and joint replacement;
  - ✓ pregnant and post-partum women are eligible for certain dental benefits (see page **4-15** of the Provider Handbook);
  - ✓ adult patients in Long Term Care or Skilled Nursing Facilities are eligible for full Denti-Cal benefits (see **page 4-11** of Provider Handbook).
  - ✓ Regional Center consumers (State Department of Developmental Disabilities beneficiaries) are eligible for full dental services through Medi-Cal.
    - See Denti-Cal Bulletin, November 2011, Volume 27, Number 13.
    - For details, contact the Denti-Cal Service Center, **800-423-0507**.

II. DENTI-CAL BILLING PROCESS

Use of the TAR/Claim form:

- The Treatment Authorization Request (TAR)/Claim form is a single form used to request prior authorization of treatment from Denti-Cal, and to file claims for reimbursement for services.
- Note **pages 2-19 and 2-20** of the Provider Handbook for a list of procedures requiring prior authorization.
- See **page 6-6** of the Provider Handbook for information on the TAR/Claim form.
- See **page 6-34** of the Provider Handbook for a checklist of information that should be provided on the claim form.

Submitted claim form:

Denti-Cal will respond to a submitted claim in one of two ways:

- It will either pay - or deny payment - for the service and communicate that to the dentist through the Explanation of Benefits (EOB) form.

…**or**…

- It will issue of a "Resubmission Turnaround Document" (RTD) form requesting additional information necessary to process the claim.

Explanation of Benefits (EOB):

- Provides details of what was paid and what was denied on a submitted claim.
- EOBs are issued as part of a bulk payment each week, and lists claims that have been in process over 18 days.
- Denials are assigned a denial code indicating why denial was made. See **page 7-35** of the Provider Handbook for listing of denial codes.
- See **page 6-43** of the Provider Handbook for more information on the EOB.

Resubmission Turnaround Document (RTD):

- Itemizes the additional information that Denti-Cal needs to process a submitted claim or request for prior authorization.
- The dentist has 45 days from the date the RTD was issued to provide the requested information to Denti-Cal.
- See **page 6-25** of the Provider Handbook for information on the RTD.
- See page 7-33 of the Provider Handbook for RTD codes and messages.

Avoiding authorization and claim denials:

On both TARs and claims:

- Assure that radiographs, if required, are of diagnostic quality and show what you are seeing as needing treatment, and…
- Assure that photographs are being submitted to support the procedure being claimed.
- Assure that radiographs and photographs are properly labeled per the Diagnostic General Policies of the Provider Handbook on **pages 5-5 and 5-6**.
- Consider whether radiographs submitted for payment of restorations demonstrate the restoration was medically necessary.
- Attach treatment notes or other written documentation to show medical necessity of procedures

claimed.

- Check the claim form to ensure all required information has been entered, and that the form is signed by the dentist. **Denti-Cal forms must be signed in blue or black ink.**

Common reasons for claim denials:

- **Incomplete or non-submission of necessary radiographs, photographs, or written documentation.**
- **Claims and documentation that fail to show that treatment was medically necessary.**
- **Radiographs and photographs not properly labeled or of non-diagnostic quality.**
- **Clerical errors such as failure to enter dates of service, failure to include treating dentist's NPI, or failure to sign claim form.**

Using a Notice of Authorization (NOA) form for prior authorized treatment:

- TARs submitted for prior authorization of treatment will generate a NOA form. Completed NOA is required to be submitted to Denti-Cal when treatment is completed.
- See **page 6-15** of the Provider Handbook for more information on the NOA.

If a claim is denied:

- When a claim or request for prior authorization is denied, check the adjudication reason code for the denial, found beginning on **page 7-1** of the Provider Handbook. When an entire document is denied, refer to the TAR/Claim Policy Codes and Messages, found beginning on **page 7-35,** in the Provider Handbook.
- Denials referenced on an EOB may be rebilled using a Claim Inquiry Form (CIF – see page **6-29** of the Provider Handbook).
- If in response to a CIF, Denti-Cal upholds the original denial, a provider may request a formal "First Level Appeal." (See page **2-11** of the Provider Handbook on both the CIF process and First Level Appeals.)

Denti-Cal provides direct assistance to dentists:
If you need live assistance on anything related to claim documentation, patient eligibility, covered benefits, call the Denti-Cal Provider Help Line at **800-423-0507.**